

**Factors Influencing Interprofessional Collaboration
on Sexual Assault Response Teams (SART):
The Role of Victim Alcohol Use and a Known-Perpetrator**

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Statement of the Research Problem

Considerable research has documented the barriers to sexual assault victims' utilization of traditional community services as well as the inadequacies of the traditional responses of the medical system, criminal justice system, and victim advocacy organizations. To improve community responses to sexual assault victims, Sexual Assault Nurse Examiner (SANE) programs have been developed to simultaneously (a) provide comprehensive, timely care to victims to minimize trauma and to promote victims' use of community services, and (b) collect high quality forensic evidence to facilitate investigation and prosecution of the offender (Ahrens et al., 2000; Campbell, Patterson, & Lichty, 2005; U.S. Department of Justice, 2004). Many SANE programs function as part of a multidisciplinary team, Sexual Assault Response Team (SART), to coordinate the response to sexual assault victims of SANEs, law enforcement, rape crisis advocates, and other community service providers.

The belief that integrating SANEs into a multidisciplinary team (SART) with law enforcement and advocacy organizations is imperative for optimal outcomes is pervasive in the research and clinical literature on SANE (Campbell et al., 2005; Derhammer, Lucente, Reed, & Young, 2000; Ledray, 2001; U.S. Department of Justice, 2004). The underlying assumption is that multidisciplinary collaboration results in better outcomes for sexual assault victims and for criminal case processing, but before this relationship can be understood, a greater understanding is needed of interprofessional collaboration (Bronstein, 2002). Yet, there is evidence that conflict between professionals exists (Cole & Logan, 2008; Crandall & Helitzer, 2003; Hatmaker, Pinholster, & Saye, 2002). Systematic assessment of the quality of collaboration between key community responders to sexual assault victims has received limited attention in the literature. In order to evaluate the interprofessional collaboration of SARTs, the research on interprofessional collaboration and multidisciplinary team work was consulted, serving as the basis for the conceptual framework for this study. Constructs and factors that have been theorized, and for which there is some empirical support for their importance in understanding

interprofessional collaboration in the health field, were included in this project as variables of interest.

Not only is it important to examine whether SARTs lead to improved interprofessional collaboration overall, but it is also important to examine the quality of collaboration in relation to victim and situational factors that have been shown to be associated with worse outcomes in traditional responses. One of the most important contributions of this project to the literature is that it explores how case characteristics may influence the quality of interprofessional collaboration on SARTs. The impact of victim blaming may be greater in cases that are typically more difficult to prosecute, such as those involving victim substance use and a known-offender, which in turn may affect the quality of collaboration among SART professionals.

The four specific aims of the dissertation project, of which only the third will be addressed in this paper, were: (1) To define effective interprofessional collaboration on formal SARTs; (2) To examine the influence of personal, structural, organizational, and interpersonal factors on the quality of collaborative interactions among SART professionals; (3) To examine the teams' philosophies and processes for responding to cases that are less difficult to prosecute and cases that are more difficult to prosecute (i.e., involving victim substance use and known-offenders) with the use of vignettes, as well as the quality of collaboration among professionals working these different types of cases; and (4) To explore the relationship between interprofessional collaboration and team members' perceptions of success in attaining team goals.

Research Background and Hypotheses

Sexual assault is a significant social problem, and one that disproportionately affects women and children. The majority of rapes are committed by men against women. Results from the National Violence Against Women Survey (NVAWS), a nationally representative telephone survey, found that 85.8% of rape victims were female and 14.2% were male, while 99.6% of female victims and 85.2% of male victims were assaulted by a male offender (Tjaden & Thoennes, 2006). In the NVAWS, Tjaden and Thoennes (2006) estimated that 1 in 7 women are raped, defined as forced oral, vaginal, or anal intercourse, at some point in their lifetime.

Research has shown that the majority of rape victims were raped by someone known to them (Kilpatrick et al., 1992; Koss et al., 1994). In the NVAWS, only 16.7% of female victims reported that the offender in the most recent rape was a stranger, with the remaining victims reporting that the offender was known to them: current or former intimate partner (43%), acquaintance (27.3%), and relative other than a spouse (22.4%; Tjaden & Thoennes, 2006).

Reviews of the literature reveals that pre-assault substance use has been associated with sexual victimization (Abbey, 2002; Testa & Parks, 1996; Ullman, 2003). A number of studies using self-report as well as official records estimate that between 50% to 74% of women raped used alcohol and/or drugs immediately before the assault (DuMont, Miller, & Myhr, 2003; Kilpatrick, Resnick, Ruggiero, Conoscenti, & McCauley, 2007; Littleton & Breitkopf, 2006; Logan, Cole, & Capillo, 2006; Seifert,

1999; Sugar, Fine, & Edkert, 2004; Ullman, Karabatsos, & Koss, 1999). Moreover, substance use is a possible consequence of sexual victimization. Individuals who have been sexually victimized have a greater risk of developing a substance abuse problem (Burnam et al., 1988; Kilpatrick et al., 1992).

Not only has considerable research found greater risk for rape by known-perpetrators and when victims have been using alcohol, but research has also shown that these factors are associated with more victim-blaming and worse criminal justice system outcomes (Kingsnorth, MacIntosh, & Wentworth, 1999; Spohn & Holleran, 2001). Evidence indicates that women who were sexually assaulted by known-offenders blame themselves more than women who were sexually assaulted by strangers (Finkelton & Oswald, 1995; Frazier & Seales, 1997). When the crime is reported to the police, suspects are identified in fewer stranger-offender cases; however, when rates of prosecution are examined for cases where a suspect is identified, cases involving a stranger suspect were more likely to be referred to the prosecutor compared to cases with an acquaintance suspect (Frazier & Haney, 1996). Moreover, some evidence suggests an interaction between partner-offender and risk-taking behavior by the victim that results in decreased victim credibility (Spohn & Holleran, 2001).

Victim substance use proximal to the sexual assault is associated with worse criminal justice system outcomes (Kingsnorth et al., 1999; Spohn & Holleran, 2001). Evidence indicates that self-blame is high among sexual assault victims who were using alcohol at the time of the assault (Finkelton & Oswald, 1995). Victim substance use at the time of the sexual assault is also associated with greater victim-blaming and diminished victim credibility from the perspective of criminal justice system personnel (Spohn & Holleran, 2001). Along with the severity of the assault, and physical evidence of the assault (McGregor et al., 2002; Wiley et al., 2003), research suggests that factors related to victims' credibility, such as the victim's character or engagement in risky behaviors such as substance use at the time of the assault, are related to the likelihood of prosecution (Logan, Walker et al., 2006). For example, in a review of prosecutors' closeout memorandums for rape cases that were cleared by arrest in 1997 in Miami-Dade, Florida, findings revealed that prosecutors' decisions to reject or pursue prosecution of a case were partly based on the victims' moral character and risk taking at the time of the incident, which includes substance use (Spohn, Beichner, & Davis-Frenzel, 2001). In sexual assault cases prosecutors make their case decisions in consideration of what they believe jurors will perceive about the case (Spohn et al., 2001). Thus, substance use by the victim before the sexual assault may have a negative effect on the criminal processing of the case because prosecutors believe it decreases victim credibility with jurors.

Methodology

This project is a multiple case study, using concurrent mixed-methods design. The use of mixed-methods allowed for a comprehensive understanding of collaboration on SARTs. The only three active SARTS with formal memoranda of agreement in the state were selected into the sample. Data collection at each of the sites involved conducting in-depth, structured interviews with SART coordinators for each SART, telephone surveys with professionals involved with SARTs (SANEs, rape crisis center advocates,

detectives, patrol officers, and prosecutors), and observation of interagency council meetings. Key informant sampling was used for telephone survey participants ($n = 79$). A total of 89 possible participants were identified with the key informant sampling, and a total of 79 surveys were completed between October 2006 and April 2007, with four individuals refusing to participate and the remaining six were never successfully contacted or completed the survey. The response rate was 89%. Surveys lasted between 25-50 minutes. Data presented in this paper are exclusively from the telephone surveys.

The protocol for this proposed project was approved under expedited review by the University of Kentucky Non-Medical Institutional Review Board. This research project was, in part, supported by the University of Kentucky Center on Drug and Alcohol Research.

Measures

A modified version of the Index of Interprofessional Collaboration (IIC, Bronstein, 2002), composed of 33 items with 5 Likert-scale responses, was used. Sums could range from 33 to 165. Higher scores represent greater collaboration. Nine of the items required reverse scoring. Because of the numerous modifications that were made to the IIC, the index for interprofessional collaboration used in this project has unknown validity. Good internal consistency reliability was found for the IIC in this sample (Cronbach's $\alpha = .832$).

The researcher's prior work analyzing data for one of the SANE programs, which included analysis of actual cases, and the research literature were used to develop and validate the vignettes. The vignettes had many similar characteristics (i.e., gender, age range, and injuries of the victim, gender of the perpetrator, time lapse from the assault to the report); however, in the first case the female victim reported using alcohol to intoxication before the assault and a perpetrator who was a former partner, whereas in the second case the victim did not report substance use and the perpetrator was an unknown person. The perpetrator in the second vignette was specified as someone the victim could identify by sight but was not acquainted with, in order to minimize the negative effect on the criminal case processing of not having a suspect identified in the non-partner case. The cases were presented to all but one of the participants, an emergency nurse who had peripheral involvement with SART. To control for the effect of the order of the presentation of the cases, the presentation of the case scenarios was counterbalanced. Forty-two (53.8%) participants heard case # 1 first, and 36 (46.2%) participants heard case #2 first.

The SART response to victims reporting alcohol use was measured in two ways. First, participants were asked if they were aware of any SART policies or protocols for responding to victims who report alcohol use around the time of the sexual assault. This question was added after piloting. Second, after the vignettes were read to participants, a series of open-ended questions was asked to elicit information on the participants' expectancy of how the cases would be handled by the following SART professionals: SANEs, law enforcement officers, and the victim advocate. Specifically, participants were asked the following question about victim alcohol use: "How do you anticipate the

victim's use of substances at the time of the assault would be discussed with the victim by all SART professionals?"

To provide a quantitative measure of the influence of case characteristics on the extent of collaboration among SART professionals and other professionals working on sexual assault cases, participants were asked to rate how much agreement they believe there would be among professionals on how to handle each case, on a scale from *1* to *10*, with *10* representing complete agreement.

Data Analysis

Data analysis included statistical tests of bivariate associations and theme coding of qualitative data. Qualitative data analysis began with a reading all of the responses to open-ended survey questions. Responses to the open-ended questions were analyzed using an iterative process of analyzing data into codes. First, coding began with the first author reading all of the open-ended responses, then creating codes to capture the responses. Second, the codes were grouped into higher order categories (Strauss & Corbin, 1998). Third, the first author coded all of the open-ended responses to each question, modifying the codes when necessary. Next, an undergraduate student independently coded 20% of the responses to each question from the telephone survey, using the codes developed by the researcher. When the interrater reliability coefficient was less than .90 for any of the questions, the first author continued to modify the codes with the student, and then the student independently coded a new sample of randomly selected cases, using the modified codes. This process had to be repeated only once for one of the questions. NVivo (v.2) software package was used to organize and manage qualitative analysis.

Results

Of the 79 surveys, 24 were completed by law enforcement professionals (e.g., detectives, patrol officers, and crime scene investigators), 22 were completed with rape crisis center staff or volunteers, 22 were completed with medical professionals (19 were SANEs), and 11 were completed with prosecutors or prosecutors' office victim advocates. The majority of participants were female (82.3%). The sample was highly educated, with 46.8% reporting that their highest level of education was a Bachelor's degree, and 32.9% had a Master's degree or other professional degree. Professionals reported a mean of 11.6 years in their current profession. Participants reported working on sexual assault cases for a mean of 8.8 years.

Formal Policies Regarding Substance Use

In response to the question about formal policies/protocols for victims using substances proximal to the sexual assault, most participants did not think there were formal policies or protocols (52%) and 16.0%, did not know. A minority of participants believed that there were policies or protocols in place (33.8%, $n = 26$). Specifically, 22.1% of participants mentioned conducting a toxicology screen and 15.6% mentioned

waiting until the victim sobered up to proceed with the exam and questioning. Only one participant mentioned that someone on the team would assess for substance abuse during the first response. However, the question as it was asked did not tap into actions professionals would take with a victim that were not specifically dictated by a protocol. Therefore, the findings cannot be construed as evidence of what individual professionals would do in response to these victims. Rather than having formalized procedures for responding to victims reporting substance use, the response may be left up to the professional judgment of individuals.

Discussion of Alcohol Use

Figure 1 presents the results of participants' responses about how SART professionals (SANEs, law enforcement officers, and victim advocates) would discuss the victim's use of alcohol with her during the first response. Most professionals mentioned that the SANEs' discussion of the victim's alcohol use would be focused on gathering information for the medical-forensic assessment: (1) "discuss it to assess whether to do a tox[icology] screen and to figure out if it was drug-facilitated"; (2) "ask about how much she drank to get an idea about her level of intoxication, because that indicates where she could consent to sex or not"; and (3) "depending on the victim's level of intoxication, the SANE might wait to do the exam"). In fact, the SANE's activities with regard to documenting evidence (i.e., providing evidence that the victim was too intoxicated to consent to sex) were seen as essential to building the criminal case. In contrast, victim advocates' discussion of the victim's alcohol use was mentioned as occurring within the context of providing emotional support. Validating that what happened to the victim was a crime and not her fault was at the core of most of the responses in this theme. For example, "Acknowledge her use but explain that her intoxication does not excuse what he did. It's still rape." Many advocates mentioned they would only discuss the victim's alcohol use with her if the victim brought it up: "I wouldn't discuss [it] unless the victim made self-blaming remarks, and I would talk about why she wasn't to blame."

Small percentages of participants believed that SANEs, law enforcement officers, and victim advocates would discuss the victim's use of alcohol within the context of giving her advice about reducing her risk for future victimization. For example, as one SANE said, "I would counsel her on precautions the same way I would the other women; not putting herself in situations where she might be a target or more vulnerable." Opinions were divided about the appropriateness of discussing the victim's use of alcohol within the context of risk reduction. Some professionals believed that their intervention might be a critical, and potentially the only, opportunity for risk reduction education to be conducted with the victim, and they felt responsible for carrying out this task. Other professionals believed that discussing risk reduction at time of crisis would only reinforce the idea that victims commonly have, which is that they are to blame for their rape. A rape crisis staff member stated, "I've observed the SANE discussing it as a risk factor for assault, which victims may interpret, especially at that time, as placing blame on them." Some professionals recognized that a victim might interpret discussion of her alcohol use as victim-blaming so they attempted to frame discussion of risk reduction strategies in a positive manner, such as stated by a detective:

We would talk with the victim, like, “As a young woman, you need to be cognizant of your surroundings. There are actions you can take to decrease your risk for crime, which does not mean that you are responsible for the assailant’s actions, but we all are responsible for our own behavior, and have a role in what happens to us.”

At least some of the SANEs and victim advocates at each site believed that some law enforcement officers would treat the victim insensitively. For example, a SANE explained, “With 30 different [law enforcement] agencies, not everyone is on board. I won’t say every officer would agree with us, but most would. A small number might operate under the assumption she was at fault or not a reliable witness.” A rape crisis therapist stated, “Some officers will use alcohol use against the victim. It has lessened since SART has begun but it still continues to a certain degree, not so much in the presence of the SANE or advocate--they’ve learned not to do this--but it may happen some when they are alone with the victim.”

Resources for Substance Use

Only four participants mentioned that someone on the team, specifically the victim advocate, would provide information on substance use or community resources for substance use to the victim during the first response. Additionally, only a couple of victim advocates mentioned that they would assess for substance abuse when responding to the victim, and these victim advocates stated that assessment would be conducted only if the victim sought services from their agency, and not at the first response.

Lower Collaboration and Greater Disagreement Associated with Victim Alcohol Use and A Known-Perpetrator

Scores on participants’ ratings of the level of agreement among professionals were significantly lower for the case involving victim substance use and a partner-perpetrator case #1 compared to case involving a sober victim and a stranger-perpetrator (7.8 vs. 9.1, $t(75) = -8.743, p < .001$). About one third of participants (32.9%) gave equal ratings of agreement for the two cases, with all other participants rating agreement higher on case #2. In addition, there were significant positive correlations between scores on the interprofessional collaboration index and agreement on case #1 ($Pearson r = .466, p < .001$), and agreement on case #2 ($Pearson r = .334, p < .001$). Thus, individuals who reported lower agreement on each of the cases perceived of lower interprofessional collaboration on their SARTs.

The most frequent explanations for disagreement among SART professionals when responding to the hypothetical cases presented in the vignettes are presented in Table 1. Significantly more participants said that there would be agreement on case #2 compared to case #1. The majority of participants responded that professionals would be in agreement on case #2. Quotes that exemplify this category are: “There won’t be anyone who says, ‘Maybe it didn’t happen. It’s a false report,’ so we would be in agreement about pursuing the case,” “I don’t see what would cause disagreement,” and “It fits the stereotype of a real rape so it would be clear what everyone would need to do.”

Significantly more participants stated that there would be disagreement about pursuing the criminal case for case #1 compared to case #2. A volunteer advocate stated, “Law enforcement might part ways to a degree from the advocate and SANE. We would want the investigation to lead to prosecution but law enforcement might have doubts.” A detective explained the need to take into account the viability of the criminal case:

Her consumption of alcohol, sketchy memory, her prior relationship with the suspect would come into play with prosecutors. It would be a tough sell. From a jury’s perspective this would be a tough sell for a rape charge. You maybe could get a lesser charge, but juries don’t convict of rape in these cases. I know that others say, “The facts are the facts,” but when you’re working these cases, you know what to expect from a jury.

Similar proportions of participants reported that there would be disagreement on both cases about how other professionals treated the victim. Just over one out of five participants (21.5%) described professionals disagreeing over someone’s reaction or treatment of the victim in case #1. For example, a rape crisis staff member explained, “Circumstances bring up more victim-blaming. We [advocates] can be more supportive than questioning, so I can see us not agreeing with the way questions are asked by law enforcement—lack of sensitivity.” A detective stated, “If you had an inexperienced patrol officer, he might unintentionally say something that would be hurtful to the victim, and this would create some friction on the team, as it should.”

Utility for Social Work Practice

Two major findings are relevant to social work practice are the following: (1) Even though substance use is an important issue for victims, the issue of how best to address substance use in the immediate aftermath of sexual assault is controversial; and (2) SART was reduced on cases that involve victim alcohol use and a known-perpetrator.

There are legitimate concerns that discussion of a victim’s substance use at the first response may reinforce the self-blame a victim may be experiencing in the immediate aftermath of the assault. First, victims’ self-blame is more likely when they were under the influence of alcohol and when they believed that their actions contributed to their victimization (Fisher, Daigle, Cullen, & Turner, 2003). Second, victims’ use of alcohol has been viewed as making others place at least some responsibility on victims for their victimization (Bourke, 2007; Girard & Senn, 2008; Norris & Cubbins, 1992; Pollard, 1992; Schuller & Stewart, 2000; Sims, Noel, & Maisto, 2007). Therefore, if support providers emphasize how the victim’s actions, such as alcohol consumption, played a role in the assault, she may experience this discussion as blaming, particularly at a time of crisis (Ahrens, 2006). In fact, some research suggests that victim self-blame may be the result of negative social reactions from others after disclosure (Ullman, Townsend, Filipas, & Sarzynski, 2007). Some research indicates that negative social reactions may be a better predictor of PTSD symptoms and psychological distress post-assault than a victim’s self-blame (Ullman et al., 2007). Even actions that are a necessary part of professionals’ work, such as asking questions about the victim’s use of intoxicating substances at the time of the assault, can be perceived as blaming (Campbell & Raja, 2005). These issues put formal support providers such as healthcare providers

and criminal justice system professionals, in a precarious position with how to best address the issue of substance use with victims of sexual assault.

Participants in this study indicated that assessment of substance abuse would be an inappropriate activity for the professionals involved with SART. Nonetheless, providing victims with information during their first contact with helping professionals after a sexual assault on positive coping strategies and ways to recognize and avoid using substances as a coping strategy may be beneficial in decreasing the risk for substance use as a self-medication or decreasing the risk of revictimization (Resnick, Acierno, Kilpatrick, & Holmes, 2005; Resnick, Acierno, Amstadter, Self-Brown, & Kilpatrick, 2007). Further, addressing the issue of substance use in a compassionate, validating way may also help to reduce victim self-blame as long as support providers clearly communicate that a victim's use of alcohol does not remove the perpetrator's responsibility for his actions. Talking about the issues surrounding the circumstances, particularly where there may be shame and self-blame, rather than ignoring them may facilitate victim recovery, as long as the discussions are framed in a nonjudgmental manner (Pennebaker, 1990).

The formation of multidisciplinary teams was undertaken, in part, to improve collaboration between community agencies and professionals. Even though professionals spoke of the improvements in professional relationships once SART was introduced into their communities, obstacles to collaboration continue to challenge professionals. Study findings indicate that collaboration on SART was reduced on cases that involve victim alcohol use and a known-perpetrator.

Tension between the dual objectives of SART was evident in the findings, particularly when participants discussed cases that had more significant legal obstacles, such as cases with victim's alcohol use and a prior sexual relationship between the victim and suspect. Displaced frustration may contribute to this heightened conflict among professionals (Scott, 1997). Participants in our study identified disagreement among professionals as largely revolving around reactions to victims or pursuit of the criminal case, both of which were related to the dual objectives of SARTs. When there are differences of opinion among professionals about approaches to victims or criminal cases, conflict is likely to occur, because at least one professional group believes the objectives of SART are not being met. Furthermore, different statutory obligations among professions may increase the likelihood of professional conflicts. The statutory threshold of evidence to which law enforcement and prosecutors are held resulted in more skepticism and doubts about pursuing the criminal case and more aggressive approaches to examining the veracity of the victim's complaint, which brought those professionals into conflict, at times, with healthcare and victim advocacy professionals. Because of the statutory requirements attached to the criminal case goal of the SART, whereby victims are treated as witnesses for the prosecution, criminal case goals appeared to be given greater weight when the dual goals were in conflict. Furthermore, greater uncertainty in decisions about assessment or interventions for particular cases may also increase interprofessional conflict and reduce collaboration, because the likelihood of professionals arriving at different conclusions is greater, resulting in higher frustration among team members (Darlington et al., 2004).

Martin (2005) asserted that when objectives clash, the victim's best interests should be put first. Further, Martin posited that because successful criminal case outcomes require cooperation from the victim, this may reinforce the benefit to the criminal justice system of making the victim's interests primary. This perspective, however, ignores that some of the tension in objectives occurs when criminal justice professionals are attempting to ascertain the legitimacy of the victim. For instance, victim advocates and some nurses perceived of law enforcement's investigative approaches (such as looking for inconsistencies in the victim's account with repeated questioning and expressions of doubt) as putting the criminal justice goal ahead of the victim-centered goal. Some of the impetus for ascertaining the legitimacy of the victim is derived from the professional's own biases and acceptance of rape myths, however, it may also be derived from the professional's obligation to spend human and agency resources wisely and not exert time and effort on false claims. Thus, the recommendation that the criminal justice system should give greater weight to the victim-centered goal when the dual objectives conflict is unlikely to be adopted. What seems clear from the data is that greater dialogue among community agencies and professionals is needed to acknowledge and negotiate conflicts before and after they arise, because building, unresolved conflict can undermine collaboration.

Practice implications of study findings include the need for initial and ongoing joint training among professionals working on SART to increase understanding, communication, and conflict resolution skills to support the development of cohesive teams, as opposed to amalgams of professionals (Kane, 1975). Funding is not a sufficient condition for collaboration, but there is evidence that it is a necessary condition (Gittel & Weiss, 2004). Some funds may be required to support the collaborative relationships (van Eyk & Baum, 2002). More funding opportunities are needed to support team efforts (SART as a whole), in particular, funding for joint training efforts. Policy implications include the need for funding of evaluation studies of SARTs and multidisciplinary training efforts. Furthermore, professionals involved in SART would appreciate and could benefit from formal evaluation of team processes and outcomes.

Future research should endeavor to link collaborative practice to team outcomes, such as victim's experiences with the SART process, victim's psychosocial outcomes, and criminal justice system outcomes.

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Table 1 *Types of disagreement among SART professionals on cases*

	Case #1	Case #2
Agreement	29.1%	73.1%*
Disagreement about pursuing the criminal case	27.8%	4.6%*
Disagreement about reaction to or treatment of the victim	21.5%	15.4%
Disagreement depends on the individuals involved	12.7%	6.4%
Conflicting objectives for the case	2.5%	0.0%

* $p < .001$

Note. Significance established using z-test for proportions.

Figure 1 *SART Professionals' Discussion of the Victim's Alcohol Use During the First Response*

